

§ 156.400

to other parties, the QHP issuer's agreement with any delegated or downstream entity must—

(1) Specify the delegated activities and reporting responsibilities;

(2) Provide for revocation of the delegated activities and reporting standards or specify other remedies in instances where HHS or the QHP issuer determines that such parties have not performed satisfactorily;

(3) Specify that the delegated or downstream entity must comply with all applicable laws and regulations relating to the standards specified under paragraph (a) of this section;

(4) Specify that the delegated or downstream entity must permit access by the Secretary and the OIG or their designees in connection with their right to evaluate through audit, inspection, or other means, to the delegated or downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP issuer's obligations in accordance with Federal standards under paragraph (a) of this section until 10 years from the final date of the agreement period; and

(5) Contain specifications described in paragraph (b) of this section by no later than January 1, 2015, for existing agreements; and no later than the effective date of the agreement for agreements that are newly entered into as of October 1, 2013.

Subpart E—Health Insurance Issuer Responsibilities With Respect to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions

SOURCE: 78 FR 15535, Mar. 11, 2013, unless otherwise noted.

§ 156.400 Definitions.

The following definitions apply to this subpart:

Advance payments of the premium tax credit has the meaning given to the term in § 155.20 of this subchapter.

Affordable Care Act has the meaning given to the term in § 155.20 of this subchapter.

45 CFR Subtitle A (10–1–14 Edition)

Annual limitation on cost sharing means the annual dollar limit on cost sharing required to be paid by an enrollee that is established by a particular qualified health plan.

De minimis variation means the allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan as established in § 156.140(c).

De minimis variation for a silver plan variation means a single percentage point.

Federal poverty level or *FPL* has the meaning given to the term in § 155.300(a) of this subchapter.

Indian has the meaning given to the term in § 155.300(a) of this subchapter.

Limited cost sharing plan variation means, with respect to a QHP at any level of coverage, the variation of such QHP described in § 156.420(b)(2).

Maximum annual limitation on cost sharing means the highest annual dollar amount that qualified health plans (other than QHPs with cost-sharing reductions) may require in cost sharing for a particular year, as established for that year under § 156.130.

Most generous or *more generous* means, as between a QHP (including a standard silver plan) or plan variation and one or more other plan variations of the same QHP, the standard plan or plan variation designed for the category of individuals last listed in § 155.305(g)(3) of this subchapter. *Least generous* or *less generous* has the opposite meaning.

Plan variation means a zero cost sharing plan variation, a limited cost sharing plan variation, or a silver plan variation.

Reduced maximum annual limitation on cost sharing means the dollar value of the maximum annual limitation on cost sharing for a silver plan variation that remains after applying the reduction, if any, in the maximum annual limitation on cost sharing required by section 1402 of the Affordable Care Act as announced in the annual HHS notice of benefit and payment parameters.

Silver plan variation means, with respect to a standard silver plan, any of the variations of that standard silver plan described in § 156.420(a).

Stand-alone dental plan means a plan offered through an Exchange under § 155.1065 of this subchapter.

Standard plan means a QHP offered at one of the four levels of coverage, defined at § 156.140, with an annual limitation on cost sharing that conforms to the requirements of § 156.130(a). A standard plan at the bronze, silver, gold, or platinum level of coverage is referred to as a standard bronze plan, a standard silver plan, a standard gold plan, and a standard platinum plan, respectively.

Zero cost sharing plan variation means, with respect to a QHP at any level of coverage, the variation of such QHP described in § 156.420(b)(1).

[78 FR 15535, Mar. 11, 2013, as amended at 78 FR 65097, Oct. 30, 2013]

§ 156.410 Cost-sharing reductions for enrollees.

(a) *General requirement.* A QHP issuer must ensure that an individual eligible for cost-sharing reductions, as demonstrated by assignment to a particular plan variation, pays only the cost sharing required of an eligible individual for the applicable covered service under the plan variation. The cost-sharing reduction for which an individual is eligible must be applied when the cost sharing is collected.

(b) *Assignment to applicable plan variation.* If an individual is determined to be eligible to enroll in a QHP in the individual market offered through an Exchange and elects to do so, the QHP issuer must assign the individual under enrollment and eligibility information submitted by the Exchange as follows—

(1) If the individual is determined eligible by the Exchange for cost-sharing reductions under § 155.305(g)(2)(i), (ii), or (iii) of this subchapter (subject to the special rule for family policies set forth in § 155.305(g)(3) of this subchapter) and chooses to enroll in a silver health plan, the QHP issuer must assign the individual to the silver plan variation of the selected silver health plan described in § 156.420(a)(1), (2), or (3), respectively.

(2) If the individual is determined eligible by the Exchange for cost-sharing reductions for Indians with lower household income under § 155.350(a) of this subchapter (subject to the special

rule for family policies set forth in § 155.305(g)(3) of this subchapter), and chooses to enroll in a QHP, the QHP issuer must assign the individual to the zero cost sharing plan variation of the selected QHP with all cost sharing eliminated described in § 156.420(b)(1).

(3) If the individual is determined by the Exchange to be eligible for cost-sharing reductions for Indians regardless of household income under § 155.350(b) of this subchapter (subject to the special rule for family policies set forth in § 155.305(g)(3) of this subchapter), and chooses to enroll in a QHP, the QHP issuer must assign the individual to the limited cost sharing plan variation of the selected QHP with the prohibition on cost sharing for benefits received from the Indian Health Service and certain other providers described in § 156.420(b)(2).

(4) If the individual is determined by the Exchange not to be eligible for cost-sharing reductions (including eligibility under the special rule for family policies set forth in § 155.305(g)(3) of this subchapter), and chooses to enroll in a QHP, the QHP issuer must assign the individual to the selected QHP with no cost-sharing reductions.

(c) *Improper cost-sharing reductions.* (1) If a QHP issuer fails to ensure that an individual assigned to a plan variation receives the cost-sharing reductions required under the applicable plan variation, taking into account § 156.425(b) concerning continuity of deductibles and out-of-pocket amounts (if applicable), then the QHP issuer must notify the enrollee of the improper application of any cost-sharing reduction within 45 calendar days of discovery of such improper application, and refund any resulting excess cost sharing paid by or for the enrollee as follows:

(i) If the excess cost sharing was paid by the provider, the QHP issuer must refund the excess cost sharing to the provider within 45 calendar days of discovery of the improper application.

(ii) If the excess cost sharing was not paid by the provider and is not requested by the enrollee as a refund, the QHP issuer must, within 45 calendar days of discovery of the error, apply the excess cost sharing paid by or for the enrollee to the enrollee's portion of